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## Men's Reproductive Health: Defining, Designing and Delivering Services

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As program planners, we often assume that a client who pursues reproductive health care meets certain criteria: She is a woman, she is married and she is in a stable, monogamous relationship where she has an equal voice in reproductive health decision-making. By holding such beliefs, however, we do clients a great disservice.

Maintaining these assumptions about clients places upon women the entire burden of preventing unwanted pregnancies and sexually transmitted diseases (STDs), of using contraceptives or of seeking treatment for infertility or for other reproductive health concerns. We have asked women to take on all of these responsibilities without thinking critically about how to encourage their male partners to share these burdens more equally. Furthermore, by assuming that family planning and reproductive health are solely women's issues, we have not educated men adequately about their own reproductive health needs.

There are several reasons why involving men in reproductive health is important. Studies show that when men are provided with information about reproductive health issues, they are likely to be increasingly supportive of their partner's family planning decisions.<sup>1</sup> Communication among partners is important to ensure that women receive the reproductive health care they need, while for STD programs to be effective, education, testing and treatment must be provided to both partners.<sup>2</sup>

Both the 1994 International Conference on Population and Development in Cairo<sup>3</sup> (ICPD) and the 1995 Fourth World Conference on Women in Beijing<sup>4</sup> provided a foundation for expanding family planning and reproductive health services to include men. For example, the ICPD Programme of Action mandates that "innovative programmes must be developed to make information, counseling, and services for reproductive health accessible to adolescents and adult men."<sup>5</sup> As we move toward a more comprehensive approach to reproductive health care, international agencies have the opportunity to reexamine existing programs and to create new ones that include men--not only as partners, but as clients as well.

### Defining Services

Reproductive health generally has been synonymous with women's health. Clinical training in reproductive health care typically has been provided through the specialty of obstetrics and gynecology. For men, however, there is no comparable clinical practice that addresses their unique reproductive health needs. Moreover, while there are many maternal and child health and women's health centers in both the public and private sectors, there are no equivalents that target men's needs. Indeed, services for men typically are housed in settings where staff lack training in male sexuality and sexual health, where providers' assumptions about men's interest in reproductive health may cause them discomfort and where the environment itself, from the decor to the posters, literature and brochures, may not reflect

men's interests or needs.

Many men--and many program planners--lack a clear understanding of what men's reproductive health means. In order to define male reproductive health services and to provide a framework for assessing men's needs and initiating or enhancing men's services, AVSC International convened a two-day meeting in April 1997 of 10 clinicians, counselors and social scientists with varied experience in providing health and social services for men. The goals of the meeting were to identify the core reproductive health services that would constitute basic reproductive health care for men and to devise a model that would serve as a framework for program development and service delivery.

Participants at the meeting agreed that services targeting men could be grouped into three categories, as shown in Table 1: screening services such as contraceptive use assessment and basic clinical care; information, education and counseling services; and clinical diagnosis and treatment services for specialized needs identified through screening.

<b>Table 1. Services included in men's reproductive health care, by whether they can be provided within a family planning clinic or through referral to other facilities</b>		
<p><b>SCREENING; BASIC HEALTH SERVICES</b></p> <p><b>On-site</b></p> <p>Comprehensive sexuality and reproductive health history-taking</p> <p>Sexual abuse and domestic violence screening</p> <p>Contraceptive use assessment</p> <p>Complete routine physical exam</p> <p>Nutrition assessment</p> <p>Cancer screening</p> <p>Screening for substance abuse and mental health needs</p> <p><b>Referral</b></p> <p>Treatment for survivors and perpetrators of sexual abuse and domestic violence</p> <p>Parenting education</p> <p>Vaccinations</p> <p>Education and employment counseling and services</p> <p>Cancer treatment</p> <p>Substance abuse treatment and mental health care</p> <p>Stress management and</p>	<p><b>INFORMATION, EDUCATION, COUNSELING</b></p> <p><b>On-site</b></p> <p>Basic sexuality and fertility education</p> <p>Sexual orientation counseling</p> <p>Sexual abuse and domestic violence information and education</p> <p>Statutory rape awareness</p> <p>Male role definition</p> <p>Comprehensive contraceptive counseling</p> <p>STD and HIV prevention</p> <p>Genital health and hygiene</p> <p>Interpersonal communication skills</p> <p>Postpartum and prenatal counseling</p> <p><b>Referral</b></p> <p>Genetic counseling</p> <p>Mastectomy partner counseling</p> <p>Sexuality and disabilities</p>	<p><b>CLINICAL DIAGNOSIS AND TREATMENT</b></p> <p><b>On-site</b></p> <p>Treatment for impotence, premature ejaculation, disorders of the reproductive system, lesions of the genital tract, hernias and varicoceles</p> <p>STD diagnosis and treatment</p> <p>HIV diagnosis</p> <p>Premarital blood tests</p> <p>Fertility evaluation</p> <p>Vasectomy</p> <p><b>Referral</b></p> <p>HIV/AIDS treatment</p> <p>Infertility services</p> <p>Treatment of urologic disease</p> <p>Vasectomy reversal</p>

violence prevention		
Runaway/homeless services		

Within these three categories, services were further classified as those that should be provided on-site and those that were beyond the scope of a basic family planning or reproductive health clinic. (These latter services could be provided by referring men to a more comprehensive health care facility or specialty clinic.)

This model reflects a comprehensive approach to men's reproductive health. Clearly, the model is not a blueprint of services that all clinics should provide; rather, it represents the menu of possibilities from which health centers in individual communities can tailor services to match their own needs and priorities.

### **Reaction to the Model**

In May 1997, the model was reviewed by panelists from Kenya, Pakistan and the United States at an interregional workshop on men's involvement in reproductive health held in Mombasa, Kenya.<sup>6</sup> Among U.S. attendees, the model's comprehensive approach--its emphasis on screening for all health services--was perceived as a strength.

By contrast, panelists from Kenya and Pakistan observed that the model represents an ideal, and that its relevance and applicability to Africa and Asia must be seen in the context of existing health care delivery systems. Since many developing countries face limited or dwindling resources for service provision, the model must be adapted for use in less-developed areas, where a program focusing on male services is likely to be sustainable only if it is integrated into an established female-oriented program.

Despite their different viewpoints, however, panelists did agree on four basic needs for men's programs: the need to provide information to men; the need to train providers to communicate with men and address their concerns; the need to create linkages to other services, both in the community and at the clinic; and the need to use existing facilities and providers.

Our model provides a framework for delivering men's services. However, it will take a committed and compassionate service provider, working closely with other community-based organizations, to make the availability of men's services a reality and a true benefit for both men's and women's reproductive health. This may entail taking a new look at how most reproductive health professionals provide health services; it may require an examination of clinic policies, staff attitudes and the clinic environment; and it may involve additional training. This is an ambitious task, and it is even more challenging given the dearth of resources available to many facilities.

### **Training and Model Testing**

In order to take a first step toward making this model a reality, AVSC International has contracted with several men's reproductive health clinicians to create a reproductive health curriculum to train service providers and to sensitize workers to the issues involved in serving male clients.

The curriculum, when fully developed, will provide reproductive health professionals with a step-by-step guide for designing and delivering services in a variety of contexts. It will cover basic information on male anatomy and physiology and instruction on examining male patients. It will also address organizational and attitudinal issues involved in providing men's services in a traditionally female-centered setting.

A suitable curriculum should challenge administrators to explore how their clinic's policies and procedures may affect service delivery to men and how to create a welcoming, male-friendly atmosphere within the clinic environment. The service approach, however, should not be one that addresses men's needs to the exclusion of women's, but rather one that considers men's and women's reproductive needs in relation to each other.

A major priority in the development of the curriculum will be its adaptability to suit a particular audience's needs and a provider's time and resource constraints. In South Africa, for example, we are working with the Planned Parenthood Association to develop a training curriculum that includes modules on domestic violence, since recent studies<sup>7</sup> have identified domestic violence as a primary health concern in the country. In India, trainers will tailor the curriculum to address the segregation of health services by sex, emphasizing modules that discuss the impact of providers' gender and communication barriers between male clients and their partners. Meanwhile, public-sector providers in Bolivia, Colombia and Mexico are interested in obtaining training to ensure their competence and comfort in working with men.

The model will undergo its first two "real world" tests in the United States and in Ghana. In the United States, several New York City-based women's health organizations working to improve men's sexual health services have expressed interest in the training. These organizations serve low-income communities of blacks, Hispanics and recent immigrants from Africa, Asia and Latin America. Similarly, the Planned Parenthood Association of Ghana recently opened three men's clinics in Accra and has reported an urgent need for clinical and management training for staff at each of these sites.

In each of these pilot sites, we will first utilize focus groups to assess the reproductive health service needs among men in the community, then launch a training curriculum for men's reproductive health to educate the providers. After we develop the protocols for enhanced service delivery, we will market the services to men and women in the community. Finally, we will evaluate the program and document the lessons learned.

Each new implementation and revision of the model will expand our understanding of male involvement and will provide useful insights into the successful development of an effective model for comprehensive reproductive health services for both men and women.

### **Challenges**

Female-centered service delivery has been a hallmark of the family planning movement over the last 30 years. The implementation of the male reproductive health model will bring new ideas and new hope to involving men in reproductive health, but it also will pose challenges and confront us with unanswered questions.

First, some reproductive health professionals believe that attempting to create and build services for men will use up scarce resources needed for serving women. Indeed, start-up costs for initiating services for men may be prohibitive in some settings. However, this model emphasizes partnership, and ultimately, potential savings may be realized through a more equitable distribution of reproductive health concerns between men and women. Our aim is both to enhance men's services and to safeguard access to existing women's services, so as to benefit both men and women.

For example, the information, education and counseling component of the model represents an opportunity to educate men about women's anatomy and reproductive health; about the particular dangers of STDs to female fertility and about the need for men to protect both themselves and their partners; about the risks and benefits for both men and women of different contraceptive methods; and

about women's issues and concerns arising during the postpartum period.

In addition, some of the clinical components of the model, such as vasectomy and treatment of STDs, directly benefit women as well, while for many of the more expensive services proposed by the model (e.g., treatment of urologic disease and infertility services), referral to an outside source would be the only alternative, given how rarely such services are available. Therefore, it would be unlikely that resources allotted to the provision of basic care for women would be used instead to offer specialized services to men.

An additional challenge of the proposed model is that the degree of instruction planned far exceeds the training offered to providers in established clinic settings serving women. Consequently, enhancing reproductive health services for men raises questions about the quality and level of care available for women through existing services. For example, some professionals argue that it is a struggle to adequately communicate about sex with female clients; to expect providers also to become proficient at discussing these issues with men may not be a realistic goal. However, the skills taught and the training modules employed in the proposed model can be applied in many settings and with a variety of client populations; they are easily transferable for clinicians focusing on women's sexuality. Clearly, providers and program planners must dedicate time and attention to ensure that women's and men's needs are met, since neither sex has been served adequately in the past.

Finally, the provision of family planning services to women traditionally has been clinic-based. Creative social marketing strategies aimed at bringing more men into clinic settings will likely be necessary, but they may not be sufficient. Making sure that services reach men often means going outside the clinic setting to seek out men in their own environments.

### **Conclusion**

Family planning as a public health "movement" has existed for more than 30 years. Now is an opportune time to examine some of our historic assumptions--about roles and responsibilities, about service delivery systems, about the actual family planning methods themselves--and to explore whether we need to change our thinking about how to best meet clients' needs.

One question we need to ask is this: By educating only women, by focusing on female-centered methods, by calling clinics "women's health centers" and offering no equivalent for men, are we really helping individual women and men? Are we really helping the family? We all understand that when a woman is anemic or, worse, dies from too-frequent childbearing, the whole family suffers. When a man is infertile or impotent, or develops prostate or testicular cancer, does not this, too, affect the entire family?

Involving men in family planning and reproductive health broadens the reproductive health agenda, but acceptance of this broadened agenda relies on improvements in health outcomes for both men and women. Focusing on men's involvement in reproductive health is designed to increase the likelihood that women's male partners are educated about, supportive of and positively involved in the range of reproductive health concerns that both women and men face.

The ICPD called for innovative programs to make reproductive health services accessible to adolescents and adult men.<sup>8</sup> Developing programs that educate and provide services to men is part of a larger effort to translate the goals of Cairo into real changes at the service delivery level by increasing the number of women and men who are served, the quality of care they receive and the likelihood that the services will be sustainable.

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